

Case Number:	CM13-0069286		
Date Assigned:	01/03/2014	Date of Injury:	06/12/2010
Decision Date:	06/02/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in New York and North Carolina. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant reports cumulative trauma as the cause of his 10/7/13 injury resulting in pain in the lumbar spine, cervical spine, shoulders, knees and ankles. He is s/p cervical surgery C4-C7, described as a hybrid reconstruction.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

CYCLOBENZAPRINE HYDROCHLORIDE 7.5 MG # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), MUSCLE RELAXANTS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-64.

Decision rationale: This medication is not recommended beyond 3 weeks of therapy. The original request was for #120 and the approval was for #20. The initial request (120) far exceeds three weeks of therapy and is hereby denied.

ONDANSETRON ODT 8 MG # 30, 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN PROCEDURE SUMMARY: ONDANSETRON (ZOFRAN).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, ANTIEMETICS.

Decision rationale: This medication is approved for chemotherapy, radiation, postoperative and acute gastroenteritis. There is no evidence that Zofran is being used in any of these scenarios, and is hence denied.

TEROCI PATCH QUANTITY 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

Decision rationale: Terocin patch composition: LIDOCAINE 600mg, MENTHOL 600mg Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. (p. 111 of Chronic Pain Treatment Guideline) Menthol is not recommended as a topical agent, and hence cannot be approved in a compounded one. The use of Terocin cannot be approved under the MTUS Guidelines.